STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	03/14/2011

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GOLDEN LIVING CENTER-MUNCIE	2701 LYN-MAR DR MUNCIE, IN47304

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F0000	This visit was for the Investigation of Complaint IN00087405. Complaint IN00087405- Substantiated, federal/state deficiencies related to the allegation cited at F223. Survey date: March 14, 2011 Facility number: 000097 Provider number 155687 AIM number: 100290970 Surveyor: Jeri Curtis, RN Census bed type: SNF/NF: 109 Total: 109 Census payor type: Medicare: 13 Medicaid: 91 Other: 5 Total: 109 Sample: 3 Golden Living Center-Muncie was found in substantial compliance with 42 CFR Part 483, Subpart B in regard to the Investigation of Complaint IN00087405. This deficiency was cited in accordance	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	with 410 IAC 16.2.			
F0223 SS=A	Based on record review and interview, the facility failed to assure physical abuse, a Registered Nurse placing a hand against the collar bone area to prevent rising, did not occur for 1 (Resident A) of 3 residents, among the sample of 3, reviewed for abuse. Findings include: During the 3/14/11, 10:00 A. M., entrance conference, the Administrator indicated the facility had received an allegation of staff to resident abuse during February of 2011. The Administrator indicated a third shift certified nursing assistant (CNA #1) had alleged inappropriate actions by a registered nurse (RN#1) toward Resident (A) following a fall.	F0223	1. The facility followed tha Abuse Policy. The allegation of abuse was immediately reported and all steps to ensure the safety of all residents were taken.2. No other residents were affected. Alert and oriented residents and other employees were interviewed and no other allegations of abuse were identified.3. Abuse Policy was reviewed and all staff re- in serviced on the policy.4. Social Services will interview random alert and oriented residents monthly and at resident council meetings on going. Results will be reviewed in QA monthly for three months and quarterly thereafter.	03/14/2011

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	The Administrator indicated he believed the incident was magnified by conflict between CNA #1 and RN #1. The Administrator indicated RN #1 had resigned during the investigation. The Director of Nursing (DoN) , who was present during the entrance conference, indicated Resident (A) was transferred to a behavior unit on 3/1/11, following another, unrelated, incident. The DoN indicated the family had decided to take (Resident A) home after discharge from the behavioral unit. The record of Resident (A) was reviewed 3/14/11, at 11:50 A.M., and indicated a 1/5/11, admission with diagnoses including, but not limited to,			

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	Alzheimer's dementia and a history of a colostomy revision. Resident (A) had 1/27/11, care plan concerns of behaviors including yelling and hitting during care. Behavioral interventions included assessing for and meeting the physical needs and explaining all procedures before beginning care. The 2/20/11, Reportable Incident indicated at 4:00 A.M., the Executive Director (ED) received a call from licensed Practical Nurse (LPN #1), who worked the secured unit. LPN #1 indicated CNA #1 had reported RN #1 was abrupt with Resident (A) after (Resident A) had pulled out a central intravenous line. After receiving the allegation, LPN #1 had done a body			

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	assessment and noted redness to the inner arms of (Resident A). LPN #1 indicated there were no abrasions or skin tears. LPN #1 also indicated when questioned, Resident (A) had said she was not mistreated. RN #1 was suspended immediately and an investigation was initiated. The final determination was no intent to harm. The DoN indicated the allegation could not be substantiated. No injuries were noted to Resident (A). A preventive measure was in-servicing of all staff on abuse prohibition. The concluding statement of the report indicated, after much consideration, RN #1 had decided to retire due to age. The DoN's investigation,			

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	conducted at 2:10 P.M. , 2/20/11, on site at the facility, was also provided for review on 3/14/11. The DoN indicated she met with the family of Resident (A), who were present at the bedside, and explained the allegation, an employee had been accused of being abrupt during the night shift. The DoN indicated the family did not notice any distraught behavior during their 2/20/11, afternoon visit. The DoN's investigation included interviews with CNAs #1 and #2, LPN #1, and RN #1, who had been on duty the night of 2/20/11. LPN #1 had stated she had received the 4:00 A.M., allegation from CNA #1 that RN #1 had abused Resident (A). CNA #1 had reported			

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	Resident (A) had been placed in a wheel chair after being found on the floor. CNA #1 had also reported RN #1 had abused (Resident A) by forcefully pushing (Resident A) back in the chair after (Resident A) attempted to get up again. LPN #1 indicated she had notified the ED, immediately requested RN #1 leave the facility, and had assessed Resident (A). LPN #1 indicated there was no redness nor pattern which would indicate a hand grip or fingerprint on Resident (A). The DoN's investigative interview with CNA #1 indicated (CNA #1) and RN #1 were on break in the lounge when CNA #2 entered twice, once to report the intravenous			

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	(IV) pulled out, and a second time to report she had found (Resident A) on the floor. CNA #1 indicated RN #1 was upset and made a comment using a curse word, stating she could not believe this, she was still on her break. CNA#1 indicated RN #1 had gone to assess Resident (A). CNA #1 indicated she went to the unit in a few minutes to see if she could help. CNA #1 indicated she witnessed RN #1 and CNA #2 pulling on the arms of (Resident A) in an effort to get the resident off the floor. CNA #1 indicated she was asked to get a chair. CNA #1 indicated RN #1 and CNA #2 got (Resident A) from the floor to the chair. CNA #1 indicated she had witnessed RN #1 push Resident			

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	(A) back after (Resident A) had attempted to get out of the chair. The DoN's investigation indicated CNA #1 had stated during the interview she did not believe RN #1 had intended harm. The DoN's investigative summary indicated the night of 2/20/11, CNA#2 had found the IV out, and had reported to RN #1, who was on break with CNA #1. CNA #2 indicated RN #1 had assessed (Resident A) and had returned to break. CNA #2 indicated minutes later, she had found Resident (A) on the floor, and had again reported to RN #1. CNA #2 indicated RN #1 had come from the break area and had started to pull Resident (A) from the floor. CNA #2			

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	indicated she assisted RN #1 with getting (Resident A) up when CNA #1 came to the area. CNA #2 indicated CNA #1 was requested to get a chair. CNA #2 indicated Resident (A) was placed in the chair, then started to lean forward. CNA #2 indicated RN #1 had used her hand and had (Resident A) back into the chair. CNA #2 indicated the hand of RN #1 was at throat level when she pushed (Resident A) down. CNA #2 indicated she and CNA #1 decided to report to LPN #1 who was on duty on another unit. The DoN's investigative summary included an interview with RN #1, who said she had been in the lounge and was summoned twice for Resident			

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	(A), once for the IV and again when (Resident A) was on the floor. RN #1 indicated she and CNA #2 had gotten Resident (A) from the floor to a geri chair, which CNA #1 was holding in position. RN #1 indicated after placement in the chair, (Resident A) started to get up again and she (RN #1) placed her hand at chest level and moved Resident (A) back in the chair. RN #1 indicated the intent was to get the feet elevated and to recline Resident (A). RN #1 indicated she did not intend harm. Interviews were conducted 3/14/11, with CNAs #1 and #2, and with RN #1, for comparison to the DoN's			

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	investigation. CNA #1 was interviewed by telephone at 2:15 P.M., 3/14/11, and indicated the beginning of the shift on 2/20/11, had been stressful. CNA #1 indicated she and RN #1 were in the break room while CNA #2 monitored the floor. CNA #1 indicated CNA #2 came to the break room to report (Resident A) had pulled out the IV and RN #1 had gone to check, then had returned. CNA #1 indicated CNA #2 returned to the break area a few minutes later and reported Resident (A) was on the floor. CNA #1 indicated RN #1 and CNA #2 went to get Resident (A) off the floor, and she followed minutes later to assist.			

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	CNA #1 indicated CNA #2 and RN #1 got (Resident A) up, while she went for a chair. CNA #2 indicated she held the chair while RN #1 and CNA #2 got Resident (A) onto her feet and into the chair. CNA #1 indicated Resident (A) raised to get back up and RN #1 placed her hand about the throat and pushed (Resident A) back into the chair. CNA #1 indicated she and CNA #2 discussed the incident,and decided it should be reported. CNA #1 indicated she reported her observation to LPN #1, who was on duty on another unit. CNA #1 indicated the Administrator had responded appropriately. CNA #1 indicated when notified, the Administrator had LPN #1			

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	suspend RN #1 immediately. CNA #1 indicated the ADoN arrived to start the investigation shortly after the allegation was reported. CNA #2 was interviewed by telephone at 4:00 P.M., 3/14/11, and indicated the night of 2/10/11, Resident (A) had pulled out the IV. CNA #2 indicated she had reported to RN #1 who was on break. CNA #2 indicated RN #1 was upset because she was on break and had to leave to assess Resident (A). CNA #2 indicated minutes later she had attended to another resident and when she came from the room, found Resident (A) on the floor. CNA #2 indicated she again reported to RN #1, who was in the break room. CNA #2			

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	indicated RN #1 came to the unit. CNA #2 indicated she and RN #1 knelt down beside Resident (A) and got her up from the floor. CNA #2 indicated Resident (A)was resistive. CNA #2 indicated CNA #1 had gone for a chair and held it while she and RN #1 stood Resident (A). CNA #2 indicated she and RN #1 placed Resident (A) into the chair and attempted to recline the position. CNA #2 indicated Resident (A) started to raise back up and RN #1 took her hand, placed it against the upper chest of Resident (A) to push her back. CNA #2 indicated the hand of RN #1 slid to the neck of Resident (A) as she pushed. CNA #2 indicated she had been shocked by the action of RN #1			

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	and she and CNA #1 had decided to report the incident. CNA #2 indicated she did not believe RN #1 had acted intentionally, however thought it should never have happened. CNA #2 indicated the Administrator had LPN #1 immediately relieve RN #1 from duty and the ADoN came in and started an investigation. RN #1 was interviewed by telephone at 4:15 P.M., 3/14/11, and indicated the night of 2/20/11, she and CNA #2 had gotten Resident (A) up from the floor and had lifted her into the chair. RN #1 indicated she and CNA #2 were in front of the resident and CNA #1 was behind, holding the chair. RN #1 indicated (Resident A) had attempted to get back out			

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	of the chair and she had placed her hand on the chest to push her back. RN #1 indicated she had not shoved (Resident A). RN #1 indicated her hand was on the collar bone area of Resident (A) as she pushed her back. RN #1 indicated she had been suspended that night immediately after the incident. The personnel file of RN #1 was reviewed 3/14/11. A 2/20/11, separation action form indicated RN #1 had voluntarily retired while on suspension. The facility's 7/1/08, revised Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Sources			

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	and Misappropriation of Property,policy was provided 3/14/11, by the DoN. The purpose of the policy was to take appropriate steps to prevent the occurrence of abuse or neglect. The corrective action section indicated the facility was to make reasonable efforts to determine the cause of the alleged violation and to take corrective action consistent with the investigation findings and to eliminate any ongoing dangers to the resident. The investigation section indicated written statements were not to be requested. Only factual information was to be documented, no assumptions, speculation, or conclusions, were to be documented. This federal tag relates to			

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	complaint IN00087405. 3.1-27(a)(1)			